| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|---------------------------|---|------------------------------|----------------------------|--|------------------|--|--|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A DITH DING 01 | | COMPLETED | | | |
| 155508 | | 155508 | A. BUILDING | | 06/29/2011 | | | |
| 100000 | | | B. WING | | | | | |
| NAME OF P | PROVIDER OR SUPPLIER | t . | | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| | | | I | OUTH SECOND ST | | | | |
| TRANSC | ENDENT HEALTHO | CARE OF BOONVILLE, LLC | BOONVILLE, IN47601 | | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | | | |
| K0000 | | | | | | | | |
| | | | | | | | | |
| | A Life Safety Co | ode Recertification | K0000 | By submitting the enclosed | | | | |
| | - | sure Survey was | | material we are not admitting | - | | | |
| | | he Indiana State | | truth or accuracy of any spe | cific | | | |
| | = | | | findings or allegations. We reserve the right to contest t | ho | | | |
| | Department of | | | findings or allegations as pa | • | | | |
| | accordance wit | h 42 CFR 483.70(a). | | any proceedings and submit | | | | |
| | | | | these responses pursuant to | • | | | |
| | Survey Date: 0 | 6/29/11 | | regulatory obligations. The | | | | |
| | | | | requests that the plan of | - | | | |
| | Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240 Surveyor: Lex Brashear, Life Safety Code Specialist | | | correction be considered out | l l | | | |
| | | | | allegation of compliance effe | • | | | |
| | | | | July 29, 2011 to the Life Safe | • | | | |
| | | | | Code Recertification Survey conducted on June 29, 2011 | | | | |
| | | | | Conducted on June 29, 2011 | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | At this Life Safe | ety Code survey, | | | | | | |
| | Transcendent H | | | | | | | |
| | | | | | | | | |
| | | was found not in | | | | | | |
| | - | h Requirements for | | | | | | |
| | Participation in | | | | | | | |
| | Medicare/Medi | caid, 42 CFR | | | | | | |
| | Subpart 483.70 | O(a), Life Safety | | | | | | |
| | <u> </u> | he 2000 edition of | | | | | | |
| | the National Fi | | | | | | | |
| | | | | | | | | |
| | Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | =" | | | | | | | |
| | basement was determined to be of | | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0DNH21

Facility ID:

000451

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 01 | | | (X3) DATE S COMPL | | |
|---|--|--|---------------|---------------|--|---|--------------------|
| 155508 | | A. BUILDING 06/29/2011 | | | | | |
| 1 | | | B. WING | EET AL | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | | | | JTH SECOND ST | | | |
| | | CARE OF BOONVILLE, LLC | | ONVI | LLE, IN47601 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID PREFIX (E. | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | TAC | | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION DATE |
| 1110 | | onstruction and was | 1710 | | | | Ditte |
| | | d. The facility has | | | | | |
| | | tem with smoke | | | | | |
| | - | oth levels including | | | | | |
| | | nd spaces open to | | | | | |
| | | The facility has a | | | | | |
| | | and had a census of | | | | | |
| | 69 at the time | | | | | | |
| | os at the time t | or this survey. | | | | | |
| | Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/30/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| following: | | | | | | | |
| | | | | | | | |
| K0050 SS=F | varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement ma | at unexpected times under , at least quarterly on each familiar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are n 9 PM and 6 AM a coded ay be used instead of 19.7.1.2 | | | | | |
| | Based on recordinterview, the factoride quarter documentation during 1 of 4 q | acility failed to ly fire drill for 1 of 3 shifts | K0050 | | K050 It is the practice of Transcendent Healthcare of Boonville to assure that fire drills are conducted at least quarterly on each shift. The correction action taken for those residents found to be | t | 07/29/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ODNH21 Facility ID:

000451

If continuation sheet

Page 2 of 7

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | (X3) DATE SURVEY COMPLETED | | | |
|---|---|------------------------------|----------------------------------|---|------------|--|
| AND PLAN OF CORRECTION | | 155508 | A. BUILDING | 01 | 06/29/2011 | |
| 100000 | | | B. WING | | 00/29/2011 | |
| NAME OF F | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC | | | I | OUTH SECOND ST VILLE, IN47601 | | |
| | | | | VILLE, 11147601 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | | DATE | |
| | • | ce could affect all | | affected by the deficient | no l | |
| | residents in the | e facility. | | practice include: There are no specific residents identified. | | |
| | | | | Please see under systems | | |
| | Findings includ | e: | | implemented to assure | | |
| | | | | compliance with this tag. Other | | |
| | Based on review | v of the facility's | | residents that have the | | |
| | Fire Drills book | on 06/29/11 at | | potential to be affected har been identified by: Potential | l l | |
| | | the Maintenance | | residents could be effected. | | |
| | | sent, the facility | | Please refer to systems | | |
| | | ve fire drills since | | implemented to assure | | |
| | June of 2010, h | | | compliance with this tag. Th | е | |
| | - | • | | measures or systematic changes that have been po | .4 | |
| | lacked written documentation a | | | into place to ensure that the | l l | |
| | | nducted during the | | deficient practice does not | | |
| | second (evenin | - | | recur include: A fire drill has | | |
| | fourth quarter (October, | | | been conducted for each sh | • | |
| | November, and December) of | | | quarter in 2011. The fire dri | | |
| | 2011. This was | s acknowledged by | | scheduled per the preventiv | l l | |
| | the Maintenanc | e Supervisor at the | | maintenance schedule to be each shift quarterly. The | rileiu | |
| | time of record | review. | | maintenance Director has b | een | |
| | | | | in- serviced related to the | | |
| | 3.1-19(b) | | following of the preventive | | | |
| | , , | | | maintenance plan The correlation taken to monitor | ective | |
| | | | | performance to assure | | |
| | | | | compliance through qualit | v | |
| | | | | assurance is: The fire drills | • | |
| | | | | be monitored as part of the | | |
| | | | | preventive maintenance rev | | |
| | | | | the quarterly QA meetings. Maintenance Director, or | ine | |
| | | | | designee, will be responsible | e for | |
| | | | | assuring that the fire drills a | | |
| | | | | completed in accordance wi | th the | |
| | | | | schedule. Any identified iss | | |
| | | | | will be immediately correcte | | |
| | | | | The Administrator, or desigr will review the preventive | iee, | |
| | | | | will review the preventive | | |

| i ' | | DENTIFICATION NUMBER: | | | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------|-------------|--|-------------------------------|------------|
| 155508 | | A. BUII B. WIN | | | 06/29/20 |)11 | |
| NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC | | | р. wiiv | 725 SO | ADDRESS, CITY, STATE, ZIP CODE OUTH SECOND ST //ILLE, IN47601 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENC | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0130 SS=F | OTHER LSC DEF | ICIENCY NOT ON 2786 | | | maintenance documentation quarterly for compliance. <i>The date the systemic changes be completed:</i> July 29, 2011 | e will | |
| | Based on observation, record review and interview; the facility failed to ensure 2 of 2 fuel fired boilers and 4 of 4 fuel fired water heaters had inspection certificates which were current to ensure the boilers and water heaters were in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, as well | | K | 0130 | K130 It is the practice of Transcendent Healthcare of Boonville to assure that fuel fired boilers and water heaters have certificates of inspection in accordance with the regulation. The correction action taken for those residents found to be affected by the deficient practice include: There are no specific residents identified. Please see under systems implemented to assure compliance with this tag. Other residents that have the potential to be affected have been identified by: Potentially all residents could be effected. Please refer to systems | | 07/29/2011 |
| | 1:00 p.m. during facility with the Supervisor, the certificates located to the certificates of the certifi | vations on een 9:45 a.m. and ig a tour of the Maintenance inspection ited next to the two | | | compliance with this tag. The measures or systematic changes that have been pure into place to ensure that the deficient practice does not recur include: The fuel fired boilers and water heaters had been inspected and now have certificates in place. The rouinspections are now schedulaccordance with the preventing maintenance schedule to asset the system of the sys | te ve ve re tine ed in | |
| | | s and four fuel ters had expiration /07. During an | | | that they are checked and certified in accordance with t regulation. The maintenance | he | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|----------------------------|---|--|--|---------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 155508 | A. BUILD | DING | 01 | 06/29/2 | |
| 155506 | | B. WING | | | 00/29/2 | 011 | |
| NAME OF PROVIDER OR SUPPLIER | | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC | | | 725 SOUTH SECOND ST BOONVILLE, IN47601 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | | TAG | DEFICIENCY) | | DATE |
| | interview at the | e time of each | | | Director has been in-services related to the certification of t | | |
| | observation, th | e Maintenance | | devices. <i>The corrective action</i> | | | |
| | Supervisor ackr | nowledged the | | taken to monitor performance to assure compliance through | | | |
| | expiration date | s on each boiler | | | | | |
| | and water heat | er and indicated he | | | quality assurance is: The fuel | | |
| | didn't think the | boilers and water | | fired water heaters and boilers will be reviewed annually to | | | |
| | heaters had been inspected since | | | | assure that inspections and | | |
| | the expiration of | dates. | | | certificates occur in accordar | nce | |
| | • | | | | with the regulation not to exc | eed | |
| | 3.1-19(b) | every two years. The | | | | | |
| | Wallie | | • | aintenance Director, or signee, will be responsible for | | | |
| | | | | | assuring that the certification | | |
| | | | | | kept current. Any identified | | |
| | | | | | issues will be immediately | | |
| | | | | | corrected. The Administrator designee, will review the | , or | |
| | | | | preventive maintenance | | | |
| | | | | | documentation related to cur | rent | |
| | | | | certificates annually for | | | |
| | | | | | compliance. The date the | | |
| | | | | | systemic changes will be completed: July 29, 2011 | | |
| K0144 | Generators are ins | spected weekly and | | | completed. July 29, 2011 | | |
| SS=F | | pad for 30 minutes per | | | | | |
| ' | month in accordance with NFPA 99. | | | | | | |
| | 3.4.4.1. | | | | | | |
| | Based on obser | | K01 | 44 | K144 It is the practice of Transcendent Healthcare of | , | 07/29/2011 |
| | interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators | | | | Boonville to assure that the generator is checked in accordance with the regulatory | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | guidelines and is equipped | | |
| | | | | | with a remote manual stop. The correction action taken for those residents found to be | | |
| | providing power | er to emergency | | | | | |
| | lighting system | is shall be installed, | | | affected by the deficient practice include: There are no | | |
| | tested and mai | | | | | | |
| | accordance wit | h NFPA 110, | | | specific residents identified. | | |
| | | | 1 | | | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155508 06/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 SOUTH SECOND ST TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC BOONVILLE, IN47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Please see under systems Standard for Emergency and implemented to assure Standby Power Systems. NFPA compliance with this tag. Other 110, 1999 edition, 3-5.5.6 residents that have the requires Level II installations shall potential to be affected have been identified by: Potentially all have a remote manual stop station residents could be effected. of a type similar to a break-glass Please refer to systems station located elsewhere on the implemented to assure premises where the prime mover compliance with this tag. The measures or systematic is located outside the building. changes that have been put NFPA 37, Standard for the into place to ensure that the Installation and Use of Stationary deficient practice does not Combustion Engines and Gas recur include: A remote shut off switch for the generator has been Turbines, 1998 Edition, at 8-2.2(c) installed in accordance with the requires engines of 100 regulation. All staff will be horsepower or more have in-serviced on the new installation of the remote shut off switch to provision for shutting down the assure that all staff would have engine at the engine and from a knowledge of how to remotely remote location. This deficient stop the generator if necessary. practice could affect all occupants The corrective action taken to monitor performance to assure in the facility. compliance through quality assurance is: The newly Findings include: installed remote shut off system will be monitored as part of the preventive maintenance plan. Based on observation on The Maintenance Director, or 06/29/11 between 9:45 a.m. and designee, will be responsible for 1:00 a.m. during a tour of the assuring that the newly installed remote shut off for the generator facility with the Maintenance is routinely checked and Supervisor, a remote shut off operational. Any identified issues device for the generator was not will be immediately corrected. found. Based on interview at The Administrator, or designee, will review the preventive 12:15 p.m., the Maintenance maintenance documentation Supervisor indicated the generator quarterly for compliance. The was over 100 horsepower, and date the systemic changes will

000451

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | | e survey pleted /2011 | | |
|---|----------------------------------|---|--|--|---------------------------|-----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 725 SOUTH SECOND ST BOONVILLE, IN47601 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE EAPPROPRIATE | (X5) COMPLETION DATE | | |
| | | ed there was no if device for the | | be completed: July | 29, 2011 | | | |